RULES
OF
TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF WORKERS' COMPENSATION

CHAPTER 0800-2-6
GENERAL RULES OF THE WORKERS' COMPENSATION PROGRAM
UTILIZATION REVIEW

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0800-2-6-.01 DEFINITIONS - GENERAL.

As used in this chapter, the following mean:

(1) "Contractor" means that organization or organizations referred to in T.C.A. §50-6-124 [Section 8 of Public Chapter 900 of the Acts of 1992].

(2) "Director" means the Director of the workers' compensation division.

(3) "Employer" means an "employer" as defined in T.C.A. §50-6-102(a).

(4) "Health care provider" means any licensed individual or entity which renders health care services, including but not limited to, chiropractors, physical therapists, physicians, surgeons, and hospitals.

(5) "Medical Director" means the medical Director appointed by the Commissioner of Labor pursuant to T.C.A. §50-6-126 [Section 10 of Public Chapter 900].

(6) "Utilization review" means "utilization review" as defined in T.C.A. §50-6-102(a) [Section 2 of Public Chapter 900].

(7) "Working day" means any day upon which the workers' compensation division is open for business.

Authority: *T.C.A. §§50-6-102, 50-6-124, 50-6-126, and Public Chapter 900, §2, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.02 UTILIZATION REVIEW SYSTEM.

(1) (a) Each insurer who provides workers' compensation insurance regulated by the provisions of T.C.A., Title 50, Chapter 6, or self-insured employer shall provide for a system of utilization review for cases involving compensable injuries under T.C.A., Title 50, Chapter 6. Utilization review conducted pursuant to these rules shall comply with the requirements of T.C.A., Title 56, Chapter 6, part 7 [Public Chapter 812 of the Acts of 1992]. Any insurer providing workers' compensation insurance under T.C.A., Title

(Rule 0800-2-6-.02, continued)

50, Chapter 6, shall provide or contract for utilization review services for workers' compensation cases.

(b) The insured employer may choose to provide the required utilization review services on its own or through a third party administrator. If so, the insured employer shall inform its insurer in writing of its choice and the insurer is relieved of its duty to provide utilization review services.

(2) The Commissioner of Labor shall provide or contract for certain utilization review services. The state utilization review services provided or contracted for shall include, but not be limited to , providing:

(a) A review of an individual case when a employee, employer, or health care provider, seeks an appeal;

(b) Review of utilization review services provided by other utilization review agents or firms for workers' compensation cases;

(c) Identification of providers who may have rendered excessive or inappropriate services to the Commissioner for appropriate action; and

(d) Development of reports and summaries of utilization of medical care and services in workers' compensation cases in Tennessee or any political subdivision of the state.

(3) Any organization conducting utilization review for workers' compensation cases pursuant to these rules shall provide to the Director of Workers' Compensation copies of any information provided to the Commissioner of Commerce and Insurance pursuant to T.C.A. §56-6-704 [Section 5(2) of Public Chapter 812].

(4) Subject to any applicable requirements of law concerning confidentiality of records, a utilization review agent shall provide the Commissioner of Labor or the Commissioner's designee with any appropriate utilization review records or permit the Commissioner or the Commissioner's designee to inspect, review, or copy such records in a reasonable manner.

(5) For utilization review purposes, the Department of Labor and its contractor will maintain any required confidentiality of any personally identifying information concerning employees claiming workers' compensation benefits which the department may obtain. Provision of these records pursuant to this rule shall not constitute a waiver of an applicable privilege or confidentiality.

(6) Specific cases may be selected for review of utilization services review pursuant to the contract between the workers' compensation division and the contractor. The contractor may attempt to contact the injured or disabled worker concerning the selection of his or her case for utilization review.

(7) The contractor is specifically authorized to communicate directly with the injured or disabled worker for the purpose of implementing its utilization review program.

(8) All employers, insurers, injured or disabled workers and their legal representatives are required to cooperate with the contractor with respect to all reasonable requests for information necessary for utilization review purposes. The contractor shall report any refusal to cooperate to the Director.

(Rule 0800-2-6-.02, continued)

(9) Any dispute concerning the reasonableness of any request for information may be submitted, in writing, to the Director. The determinations of the Director concerning the reasonableness of such requests are final. The Director shall consult with the medical Director in making such determinations.

(10) The worker's employer, insurer or third party administrator shall provide a copy of written utilization review reports to the contractor on request.

(11) The contractor or the employer's utilization review provider shall make its written report concerning utilization review available to the injured or disabled worker and/or his or her legal representative, upon written request.

(12) All employers, insurers, employer utilization review providers and third party administrators of cases involving injured or disabled workers are required to communicate and provide information to the contractor on request for the purpose of facilitating utilization review. The employer, insurer and/or third party administrator shall be required to cooperate and provide information, without charge, to the contractor.

(13) The Director may review any report provided by the contractor and any other information provided to the Director.

(14) Any employer, insurer, or third party administrator may provide, either directly or through contract with another organization, utilization review and/or case management services with respect to any or all medical treatment provided pursuant to the Workers' Compensation Act, or the Workers' Compensation Reform Act of 1992. The above services may be implemented at any time prior to the mandatory case management thresholds established in paragraph (a) ofRule 0800-2-7-.03 if such services would prove to be beneficial.

Authority: *T.C.A. §50-6-124 and Public Chapter 900, §8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.03 INFORMING EMPLOYEES.

It shall be the responsibility of every employer, either directly or through its insurer or third party administrator, to give basic information to and encourage the injured worker's participation in utilization review. It shall further be the responsibility of those parties to inform the injured worker of the identity of the contractor and of the utilization provider for workers' compensation cases for the employer, the possibility that the injured worker will be contacted by the utilization review provider for the employer, and the fact that provision of information to the contractor and to the utilization review provider for the employer for purposes of utilization review is strongly encouraged.

Authority: *T.C.A. §50-6-124 and Public Chapter 900, §8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.04 PRE-ADMISSION REVIEW.

(1) Subject to the requirements of T.C.A. §56-6-705 [Section 6 of Public Chapter 812], each employer or the employer's insurer covered by those rules shall establish and maintain a system of preadmission review of in-patient hospital care in non-emergency cases for employees claiming benefits under the Workers' Compensation Law. In emergency cases, the hospital shall notify the employer's utilization review agent or the Department of Labor's utilization review program within one (a) working day of admission. In non-emergency cases,

planned or elective hospital admissions shall be reviewed for medical necessity prior to admission.

(2) Any health care provider, excluding hospitals, ordering the admission of an injured or disabled worker for evaluation or treatment of his or her injury or occupational disease disablement shall report to the employer's utilization review provider, at least forty-eight (48) hours prior to any overnight admission, all the information required by the Rule with regard to planned overnight admissions of injured or disabled workers.

(3) Any health care provider or hospital discharge planner ordering or arranging a transfer of an injured or disabled worker to another inpatient facility shall report to the employer's utilization review provider, at least twenty-four (24) hours prior to any transfer, all information required by this chapter with regard to planned overnight admission of injured or disabled workers; provided, however, that the hospital discharge planner, if any, shall be primarily responsible for satisfaction of this requirement.

(4) The employer's utilization review provider shall determine if it has been provided with all necessary information, pursuant to Rule 0800-2-6-.12 of this chapter, to render its decision concerning the necessity, appropriateness and length of stay of the proposed admission.

(5) If adequate information has been provided, the employer's utilization review provider shall:

(a) Render a decision concerning the necessity, appropriateness and length of stay of the proposed admission based upon medically accepted standards and an objective evaluation of the circumstances of the proposed admission;

(b) Verbally notify the hospital, payer and health care provider ordering the admission of its decision prior to the commencement of the proposed admission; and

(c) Transmit written notification to the hospital, payer and health care provider ordering the admission within twenty-four (24) hours of its decision.

(6) The health care provider, employer, insurer and third party administrator are specifically informed that, in the case of a compensable injury or disability, the employer, or its insurer, retains all financial responsibility for those health care services that are provided.

(7) If the employer's utilization review provider does not possess adequate information to render its decision prior to admission, the employer's utilization review provider shall verbally inform the hospital, health care provider and payer that it is unable to render a decision. The employer's utilization review provider shall, prior to the proposed admission, issue a written report to the hospital, health care provider, payer and workers' compensation division of all failures to provide information that is adequate to allow it to render a decision.

(8) Every hospital, as defined in T.C.A. §68-11-201, shall provide to the employer's utilization review provider, before the close of business the next working day following any emergency overnight admission of an injured or disabled worker, all information required by this chapter to be provided by a hospital for planned/elective hospital admissions.

(9) Not later than the next working day, after information has been provided pursuant to this chapter, the employer's utilization review provider shall provide a verbal certification or denial concerning the emergency overnight admission to the hospital, health care provider and payer with respect to the medical necessity of hospital services, diagnostic testing fees, treatments and procedures, the appropriateness of inpatient services, and the assigned length of stay, if any.

(Rule 0800-2-6-.04, continued)

(10) The verbal certification or denial shall be confirmed in writing and transmitted by the employer's utilization review provider within twenty-four (24) hours of its decision.

Authority: *T.C.A. §50-6-124 and Public Chapter 900, §8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed May 13, 1997; effective July 27, 1997. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.05 OUTPATIENT REVIEW.

(1) Each employer or employer's insurer covered by these rules shall establish and maintain a system of utilization review of outpatient medical care in outpatient cases involving employees claiming benefits under the Workers' Compensation Law.

(2) Utilization review shall be applied to outpatient cases involving employees claiming benefits under the Workers' Compensation Law when the injury results in medical costs in excess of five thousand dollars ($5,000).

Authority: *T.C.A. §50-6-124 and Public Chapter 900, §8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.06 INPATIENT SERVICES.

Throughout the period of time in which inpatient services are being provided to the injured or disabled worker, the employer's utilization review provider shall monitor the injured worker's condition, treatments, procedures and length of stay for medical necessity and appropriateness. All health care providers, as defined in Rule 0800-2-6-.01, are required to cooperate with the contractor and employer's utilization review provider for concurrent review of hospitalization and are required to provide, without additional charge to any party, any available medical information requested by the contractor or employer's utilization review provider for that purpose. Any dispute concerning the reasonableness of the request for information by the employer's utilization review provider or contractor for purposes of concurrent review shall be determined by the Director upon the written request of any party. All determinations of the Director pursuant to this chapter shall be final.

Authority: *T.C.A. §§4-5-202, 50-6-124, and Public Chapter 900, §8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed March 15, 1995; effective July 28, 1995. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.07 APPEALS OF CERTIFICATION DECISIONS.

Any party aggrieved of a decision of the employer's utilization review provider concerning pre-admission, outpatient or inpatient review certifications, who has appealed such decision under the appeal procedure established pursuant to T.C.A. §56-6-705 (Section 6 of Public Chapter 812 of the Acts of 1992), may request in writing that the medical Director review the employer's utilization review provider's decision concerning certification or denial of hospitalization. With the assistance of the contractor, as needed, the medical Director shall obtain a second medical opinion by its peer review consultant with respect to such requests for review and shall expeditiously respond, in writing, to the injured or disabled worker, employer, insurer, hospital, health care provider and third party administrator, if any, concerning the results of its review.

Authority: *T.C.A. §§4-5-202, 50-6-124, and Public Chapter 900, §8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed March 15, 1995; effective July 28, 1995. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.08 EXCESSIVE OR INAPPROPRIATE UTILIZATION.

(1) The Commissioner may find that a health care provider has rendered excessive or inappropriate services or care when the services or care were not medically necessary or justified.

(2) If the Commissioner finds that any health care provider has rendered inappropriate services, the Commissioner may proceed in accordance with Rules Rule 0800-2-6-.09, and Rule 0800-2-6-.10; provided, however, that if the excessive or inappropriate services have been explicitly ordered by another health care provider, the ordering health care provider shall be held primarily responsible by the Commissioner.

Authority: *T.C.A. §§50-6-124, 50-6-233(c)(4) and (5), and Public Chapter 900, §§3 and 8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.09 SANCTIONS.

(1) If after consultation with the Medical Director, the Commissioner finds that a provider has rendered excessive or inappropriate services, the Commissioner shall give notice of such finding with a recommended sanction to the provider pursuant to Rule 0800-2-6-.10. If the provider desires to contest an order of the Commissioner imposing the sanction or civil penalty, then Rule 0800-2-6-.11 shall apply.

(2) Pursuant to the utilization review conducted by the Commissioner, including providing an opportunity for a hearing, any health care provider who is found by the Commissioner to have rendered excessive or inappropriate services may be subject to:

(a) A forfeiture of the right to payment for those services that are found to be excessive or inappropriate; or

(b) A civil penalty of not less than one hundred dollars ($100) nor more than one thousand dollars ($1,000); or

(c) A temporary or permanent suspension of the right to provide medical care services for workers' compensation claims, if the health care provider has established a pattern of violations.

(3) A forfeiture pursuant to subparagraph (2)(a) of this rule shall be a sanction in addition to any action that an employer or insurer might undertake pursuant to contract or law. Any sanction imposed by this rule is in addition to any other sanction or action permitted by contract or law.

Authority: *T.C.A. §§50-6-124, 50-6-233(c)(4) and (5), and Public Chapter 900, §§3 and 8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.10 INFORMAL SHOW CAUSE HEARINGS.

(1) Before the Commissioner takes action to assess civil penalties against a provider for rendering excessive or inappropriate services, the Commissioner shall send a written notification to the provider, informing the provider of the allegations against them and amount of civil penalties or sanction involved with the possible violation. Additionally, this notification must inform and provide the provider with the opportunity to choose one (a) of the following options:

(Rule 0800-2-6-.10, continued)

(a) The provider must be provided an opportunity to personally appear before a hearing officer selected by the Commissioner to show why sanctions should not be imposed or civil penalties should not be assessed; or

(b) The provider must be provided an opportunity to submit a sworn statement which has been sworn to before a notary public, along with any pertinent attachments, to show why sanctions should not be imposed or any civil penalties should not be assessed.

(2) The opportunity provided to a person to personally appear before a hearing officer or to submit a sworn statement for the consideration as to whether to assess sanctions or civil penalties against the provider is not in lieu of any contested case hearing rights that the provider may have pursuant to Tennessee Administrative Procedures Act, T.C.A. §4-5-301, et seq.

(3) In order for a provider to take advantage of the opportunity to personally appear before a hearing officer, the provider must request such an appearance in writing. A provider has the right to appear with legal counsel at the meeting.

(4) In order for a provider to take advantage of the opportunity to submit a sworn statement, along with any pertinent attachments for the determination as to whether to assess sanctions/civil penalties, the statement and any attachments must be received in the Commissioner's office.

Authority: *T.C.A. §§50-6-124, 50-6-233(c)(4) and (5), and Public Chapter 900, §§3 and 8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.11 ISSUANCE AND APPEAL OF SANCTION AND CIVIL PENALTY ASSESSMENT ORDERS.

(1) An order assessing civil penalties or other sanctions shall be mailed to the provider to whom the order is issued, and the party to whom it is issued shall be provided thirty (30) days from the date of issuance of the order to either appeal the Commissioner's order pursuant to the procedures provided for under Tennessee's Administrative Procedures Act, T.C.A. §4-5-301, et seq., or to pay the assessed penalties to the Department of Labor or otherwise comply with the order.

(2) In order for a provider to appeal an order issued by the Commissioner assessing civil penalties or sanctions, the provider shall file a petition with the Commissioner. This petition shall be considered a request for a contested case hearing pursuant to the Uniform Administrative Procedures Act, T.C.A. §4-5-301, et seq.

(3) If the Commissioner's order assessing civil penalties or sanctions is not appealed within thirty (30) days of its issuance by the provider, the order shall become a final order.

(4) Upon the order becoming final, the Commissioner shall forward the matter to the legal counsel of the Department of Labor. The Commissioner shall request that the legal counsel take legal action on the Department's behalf to collect any civil penalties from the party against whom the action has been taken.

Authority: *T.C.A. §§50-6-124, 50-6-233(c)(4), 50-6-233(c)(5), and Public Chapter 900, §§3 and 8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.12 DATA ELEMENTS FOR UTILIZATION REVIEW.

For a case involving an employee claiming benefits under T.C.A., Title 50, Chapter 6, a utilization review agent shall obtain the following information from an attending physician or other health care provider:

(1) Employee/Employer Information

(a) Employee:

1. Name/Address

2. Date of Birth

3. Sex and Social Security Number (or HMO ID Number)

4. Name of Carrier or Plan (Per ID Card)

Employer:

5. Name/Address

6. Identification Number FEIN

7. Other Coverage Plans

(b) Physician

1. Name and Address

2. Telephone(s)

3. Degree/Specialty

(c) Clinical Information

1. Primary Diagnosis and ICD/DSM Code

2. Secondary Diagnosis

3. Procedure(s) or Treatment(s)

4. Second Opinion Requested?

5. Second Opinion Waived?

(d) Clinical Information

1. Clinical Information to Support Appropriateness and Level of Service Requests (H & P, Lab, X-ray, etc.)

2. Discharge Planning Likely?

(e) Resources

1. Facility

(Rule 0800-2-6-.12, continued)

2. Name
3. Phone
4. Address
5. Surgical Assistant?
6. Anesthesia?
7. Proposed Admission/Visit Date(s)
8. Proposed Procedure Date(s)
9. Requested LOS

(f) Utilization Review Outcome

1. Approval Information
2. Authorized Days/Visits
3. Date
4. Utilization Review Organization/Contact/Phone

(g) Continued Stay

1. Date
2. UR Organization Contact
3. Clinical Contact
4. Additional Days/Visits Requested
5. Reasons for Extensions
6. Diagnosis
7. Treatment Plan

Authority: *T.C.A. §50-6-124 and Public Chapter 900, §8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007.*

0800-2-6-.13 PAYMENT FOR SERVICES.

(1) In no event shall any injured or disabled worker, employer, insurer, third party administrator, or their legal representatives be empowered to obligate the workers' compensation division to pay for any services provided by the contractor.

(2) All hospitals shall submit their bills for treatment to injured or disabled workers to the workers' compensation insurance carrier, self-insured employer or third party administrator designated

(Rule 0800-2-6-.13, continued)

as the responsible party. In no event shall bills be presented for payment by the workers' compensation division or the contractor.

(3) In no event shall the injured or disabled worker be considered a responsible party for reasonable and necessary health care services rendered for the treatment of compensable workers' compensation claims or occupational disablement claims except as provided by T.C.A. §50-6-122 [Section 6 of Public Chapter 900 of the Acts of 1992].

(4) The auditing of bills and contesting of charges pursuant to those audits is specifically not prohibited by these Rules. The auditing of hospital bills will not be provided by the workers' compensation division or through its contractor.

Authority: *T.C.A. §§50-6-122, 50-6-124, 50-6-126, and Public Chapter 900, §§3 and 8, Acts of 1992.* ***Administrative History:*** *Original rule filed March 5, 1993; effective April 19, 1993. Amendment filed October 12, 2007; withdrawn December 12, 2007.*